

increased amount of albumen in tuberculous exudates. It is easily done; no anaesthesia is necessary, and the dorsal muscles do not impede one.—*Wiener Medizinische Presse*, No 19, 1893.

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#### HEAD AND NECK.

**I. Preliminary Ligation of the External Carotid in Operations Upon the Face.** By Dr. CHALOT (Toulouse, France). After having considered the inconvenience of ligaturing the common carotid, and its being followed, in a quarter of the cases, by softening of the brain, the writer proposes preliminary ligation of the external carotid in operations for cancers of the face and the upper portion of the neck. He goes into the details of the operative procedure, speaks of the uncertainty of finding the hypoglossal nerve, the importance of doubly ligating the superior thyroid vein which, if not cut between two ligatures, will inundate the field of operation, and render further progress difficult. He bases his considerations upon thirteen cases in which he has done this procedure within eighteen months.—*Le Progrès Médical*, No. 15, 1893.

**II. Contribution to the Treatment of Cleft Palate.** By Prof. KUESTER (Marburg, Germany). Kuester reported on his results in the treatment of cleft palate, before the German Society of Surgery, at their Twelfth Congress. He has, in all, operated on twenty-two cases, of which thirteen were females and nine males, and varying in age from two and a half to thirty-six years. The last ten patients were all cured by a single operation. He employs Langenbeck's method, anaesthetizing the patient and operating with the patient's head hanging down. He modifies the freshening up of the edges in that he pierces the middle of the uvula by a two-edged knife and forms a flap, extending on both sides, to the posterior border of the hard palate. In this manner the velum palati and the uvula are lengthened and broadened so that it is easily

applied to the bony surface. He avoids further cutting through the velum and severing the tensor palati, but rather does he incise the velum only so far as to cut the nasal mucous membrane with a button-tipped bistoury, where it passes over into the soft palate from within outward. Thus, any further incisions for relief of tension are rendered unnecessary. In applying the sutures to the uvula, a silk thread is passed through and held to act as a guide and to oppose tension. The whole operation lasts from one-half to three-quarters of an hour. The sutures are painted with iodoform-collodion, and a tamponade of iodoform-mull employed in case of profuse haemorrhage, and then only a few minutes. Thus primary adhesion to the exposed bone is more certain to follow. He rejects Julius Wolff's method of making lateral incisions, with employment of silver wire sutures to relieve tension, as disadvantageous, and to favor lateral defects. Daily irrigation of the nose is also unnecessary. Wolff's operation in two sittings for the prevention of atrophy of the flaps is only justifiable in case of a very broad fissure and very narrow flaps. To avoid gangrene of the margins of the wound he has used in several the tertiary silver wire suture. One can assist the healing of the wound by painting it with tincture of cantharides, and then, if complete closure does not take place, the granulating edges may be closed with silver wire sutures. In nervous patients it is advisable to use a buccal dilator and anaesthesia. If a small spot remain open it may be helped to close by the tincture of cantharides. In order to obtain a good functional result, it is not only necessary to obtain a complete closure of the palate and a sufficiently large uvula, but also of a proper training in speaking. Speech training, according to Gutzmann, should even precede the operation. Two cases treated after this method succeeded in obtaining ideal speech. Out of the other seven five had normal speech, one was only moderately improved and another remained uninfluenced. The writer is of opinion that it is not advisable to operate as early as possible, for he does not consider it dangerous to life, and the aural and pharyngeal and laryngeal catarrh, which often complicate, rapidly retrogress,

even in later life. He looks upon the fifth to the seventh year as the most appropriate time to interfere.—*Wiener Medizinische Presse*, No. 18, 1893.

### III. Voluminous Enchondroma of the Parotid Gland.

By Dr. LEVRAT (Paris). The writer removed an enormous enchondroma, weighing six kilograms, from the parotid region of a man sixty years of age. The tumor had been developing for ten years. Its removal was accompanied by a profuse haemorrhage, and necessitated the ligation of forty-five arteries, of which five or six were as large as the carotid. In spite of this the patient made a good recovery, though it recurred after two years.—*La Semaine Médicale*, No. 23, 1893.

### IV. Contribution to the Study of Injury of the Uppermost Vertebrae.

By Dr. BERNDT (Vienna, Austria). The writer describes the case of a woman, seventy-nine years old, who fell headlong down a flight of stairs, fracturing the odontoid process of the atlas, and determining a right-sided luxation of this bone, with consequent compression of the right side of the cord. The patient lived thirty-one days, and the necropsy confirmed the diagnosis. The clinical phenomena were, on the side of the lesion motor and vaso-motor paralysis, with increased sensibility, while an anaesthetic zone above the hyperaesthetic region, with a hyperaesthetic zone above this, were lacking on account of the high situation of the injury. The patellar and plantar reflexes were, at first, decreased on the right side, but later the opposite was remarked. On the contrary side, opposite to the lesion, there was complete anaesthesia up to the margin of the chin without a hyperaesthetic region above this. At the same time active motility was retained, only lifting the left arm being somewhat difficult during the first three days. At first, the patellar and plantar reflexes were normal, but later, weaker than on the right. Less characteristic sensations were pain in the back of the neck, transient, and in the left arm, which later were nearly

constant, slight albuminuria, obstinate constipation and retention of urine; from the fifteenth day there was complete paralysis of the intestines. The right pupil was very small, while the left was dilated. It was interesting to note that the cubital bedsores were larger and increased in size more rapidly on the side where sensation was paralyzed than the other, though she laid exactly flat upon her back.—*Wiener Medizinische Presse*, No. 18, 1893.

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#### CHEST AND ABDOMEN.

I. **Incision and Drainage of the Pericardium in Purulent Pericarditis.** By R. SIEWERS (Helsingfors, Finland). The pericardium has only lately been the object of operative interference, yet this question was early discussed. Riolanus (1653) was the first who spoke of the possibility of opening the pericardium, advising trepanation of the sternum. Senac (1794) proposed puncture by means of a trocar. Desault, at the beginning of this century, attempted to operate on a case, but it turned out to be a false diagnosis, a pleuritic exudate. Romero, of Barcelona, operated on three cases, in 1819, by incision in the fifth intercostal space; two of his cases recovered. In the meantime, it was only after 1840 that an adequate number of cases had accumulated. Roger (1875) found paracentesis of the pericardium indicated in very large exudates and in primary purulent pericarditis. Hindenlang (1879) claims the operation to be indicated in idiopathic and secondary, rapidly developing, pericarditis as well as in the haemorrhagic form, as seen in scurvy and purpura haemorrhagica. West (1883) refers to seventy-nine cases, with thirty-six recoveries. He states that paracentesis is a justifiable operation, and that it can be done without any great danger, that the best point of puncture is the fifth intercostal space, an inch from the left border of the sternum. Billroth (1882) rejected the operation and spoke very decidedly against it. Fevret (1889) sets forth the following indications: (1) When the exudate reaches